Treatment Plan Review
Agency Name
Agency Address

Identifying Information

Name: Age:
Client ID: Gender:
Parent or Legal Guardian:
Individual(s) present:

Service Rendered: Treatment Plan Review
Setting of Service:
Start Time: End Time: Duration:
Service Provider:

Treatment Services Rendered:
Type of treatment services provided
Treatment modality used to provide services
Duration of service provided

Treatment Progress:
Identify treatment goals
Describe treatment progress related to treatment goals and domestic violence
Describe barriers to treatment progress

Statement of disability and need for Continued mental health therapy:
Based on mental health treatment goals and progress to date

Summary and Recommendations:
Summarize course of treatment to date and identify the next treatment review or completion of service date
Make recommendations regarding revisions to the treatment plan, client prognosis, treatment methods,therapeutic modalities, discharge criteria or plans

I have reviewed the treatment plan review with the client: Y /N

Client Signature: Date:

Parent Signature: Date:

Licensed Therapist Signature: Date:
Include credential and title

Clinical Supervisor Signature: Date:
Include credential and title
(If Necessary)